North Dakota Veterans Home-Basic Care
1400 Rose St. /PO Box 673
Lisbon, ND 58054-0673
Telephone number: (701) 683-6530 Fax number (701) 683-6550

Thank you for your interest in the ND veterans Home. Your application will be given immediate attention. You can help the application process by submitting the following documents or information with your application.

Application- fully completed

Medical

The Veterans Home will be using the VA Form 10-10SH for the medical certificate. This needs to be completed in its entirety. Results of chest x-ray of applicant with in the past 6 months. We are unable to process an application with out the 10-10SH form completed.

Documents
Copies of the following

DD214 (Report of Separation, Military Record of Service)
Widow(er) needs to submit veteran's death certificate
If applicable: Guardianship papers, conservatorship paper, Power of Attorney, Durable Power of Attorney
Copy of current Drivers License

Insurance Information

Copies of insurance cards, including Medicare and secondary insurance if applicable
Copy of current vehicle insurance

Financial Information

Verification of income and assets:
Copy of last bank statement

After the application is received, it is reviewed for completeness, eligibility and level of care. The applicant or interested party will receive a call from the Admission's Office to schedule an admission date and time, indicate placement on waiting list, or advise you if we are unable to meet the needs required. A letter will follow the phone call.

Thank you for your cooperation. If you have any questions or wish to know the status of your application, please call (701) 683-6530

APPLICATION FOR ADMISSION
NORTH DAKOTA VETERANS HOME
BASIC CARE UNIT
PO Box 673, Lisbon, ND 58054
Phone: (701) 683-6530, Admissions Coordinator

Personal Information:

Name: _____ Phone:_____
(Last, First, Middle Initial)

_____ _____ _____ _____
Permanent Address City County State

_____
Where have you lived in the past 2 years? (City, County, State)

_____
Social Security Number

_____ _____ _____ _____
Date of Birth Age Place of Birth Religion

_____ _____
Father's Name Living or Deceased?

_____ _____
Mother's Name Living or Deceased?

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

_____ _____ _____
Name of Spouse Address Phone Number

Is there a Power of Attorney established? ☐ Yes ☐ No
Name & Address of Power of Attorney _____

_____

Is there a designated Legal Guardian? ☐ Yes ☐ No
Name & Address of Guardian _____

_____

Do you own your own vehicle? ☐ Yes ☐ No _____
_____
Year Make

Do you have auto insurance? ☐ Yes ☐ No _____ _____
Company Name Policy Number

Do you have a driver's license? ☐ Yes ☐ No _____ _____ _____

Driver's License # Exp. Date Vehicle License #

Do you have a police or criminal record? ☐ Yes ☐ No

If yes, briefly describe if it was a felony:

_____

Have you ever been a member of the Veterans Home? ☐ Yes ☐ No

Reason for leaving:_____

_____ _____

Previous Occupation Last date of employment

Who would you like notified in case of an emergency?

Name Address/Phone Relationship

_____

_____

_____

Financial Information:

Do you handle your own funds? ☐ Yes ☐ No

If no, please explain:_____

Income Source:	Gross Monthly:	Monthly Debts:	
VA	$_____	Medicare	$_____
VA Pension	$_____	Private Insurance	$_____
VA Compensation	$_____	Medications	$_____
Social Security	$_____	Other	$_____
Social Security Disability	$_____		
Retirement	$_____		

Do you pay co-pay for medications at the VA? ☐ Yes ☐ No Amount: $_____

Type of assets: Amount:

Checking Account

$_____

(Name & Address of Bank)

Savings Account

$_____

(Name & Address of Bank)

Automobile $

Real Estate

$

(Describe)

Other Property

$

(Describe)

Who will pay your bills? ☐ Self ☐ Other _____-

_____

Name & Address

Insurance Information:

Are you eligible for Medicare? ☐ Yes ☐ No _____

Medicare Number

_____ _____

Part A effective date Part B effective date

Are you covered by Medicaid? ☐ Yes ☐ No _____

Medicaid Number

Do you have other health insurance? ☐ Yes ☐ No

Name & Address of insurance company _____

_____

_____

Insurance Numbers _____

Military Information:

Service in the Armed Forces: ☐ Self ☐ Spouse Dates of Service: _____ to _____

_____ _____ _____

Type of discharge Branch of Service Rank

_____ _____

_____

Serial Number Claim Number Service organization with Power of Attorney

Veteran	☐ Yes ☐ No	Service in Persian Gulf Theatre	☐ Yes ☐ No
Prisoner of War Where?	☐ Yes	Dental injury	☐ Yes

	☐ No		☐ No
Combat Service	☐ Yes ☐ No	Service Connected _____ %	☐ Yes ☐ No
Military Disability (retired from military for disability)	☐ Yes ☐ No	Receiving Aid and Attendance	☐ Yes ☐ No
Vietnam Service	☐ Yes ☐ No	Receiving Housebound	☐ Yes ☐ No
Lebanon Service	☐ Yes ☐ No	Receiving VA Pension	☐ Yes ☐ No
Panama Service	☐ Yes ☐ No	Receiving VA Disability	☐ Yes ☐ No
Persian Gulf Service	☐ Yes ☐ No	Service in Somalia	☐ Yes ☐ No

Are you currently receiving VA Compensation for a service connected disability? ☐ Yes ☐ No

If yes, what is your VA compensation for?
_____

What
condition?_____

Are you receiving Aid and Attendance from the Veterans Administration? ☐ Yes ☐ No

Do you have a VA outpatient card? ☐ Yes ☐ No

Do you use the Fargo VA system for medical care? ☐ Yes ☐ No

I understand that under the Title VII of Civil Rights Act of 1964, I can not be discriminated against based on race, color, religion, national origin, sex, or on the basis of age, physical, or mental handicap.

★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★ ★

Signed this _____ day of _____, 20____,
_____.

_____
Signature of Applicant

_____

Application explained and witnessed by

.....

CERTIFICATION OF RESIDENCY

This is certify that _____ has been a resident of North Dakota for 30 days and a resident of _____ County prior to date of this application and is personally known as the individual whose name appears on this application.

_____	_____	_____
Print Name	Signature of Witness	Title